PODIATRY PROGRAM MANUAL

Kentucky Medicaid Program
Podiatry Benefits
Policies and Procedures

907 KAR 1:270

PODIATRY PROGRAM MANUAL

July 1, 1997

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

PODIATRY MANUAL

POLICIES AND PROCEDURES

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Division of Individual and Clinic Providers
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INTRODUCTION

SECTION I

SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Podiatry Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. In addition, providers are subject to provisions in 907 KAR 1:280, 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define

"Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months shall elapse between EACH RECEIPT of the aged claim by the Program.

C. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager and pharmacy shall appear on the face of the card.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Podiatry provider numbers have a prefix of "80". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated or suspended from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date shall not be payable.

B. Provider Freedom of Choice

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided.

C. Medicaid Participation Overview

All podiatrist's licensed to practice podiatry in the Commonwealth of Kentucky (or in the state in which they practice) may participate in the Kentucky Medicaid Program.

The provider shall complete the provider agreement forms, (MAP-343, MAP-343A, MAP-343B, and the provider information form (MAP-344), in accordance with 907 KAR 1:672. All participating providers shall comply with the requirements specified in 907 KAR 1:280, 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673. One (1) copy of each form shall be returned to the Department, along with a copy of the podiatrist's current license and a provider number shall be assigned to the podiatrist. The number serves to identify claims submitted to the Program, and shall be utilized in the preparation of all payment records.

Providers shall maintain the medical records as are necessary to fully disclose the extent of the service provided by the podiatrist. The medical records must be accurate and appropriate, and entered personally or countersigned by the podiatrist. ALL RECORDS SHALL BE SIGNED AND DATED BY THE PODIATRIST.

SECTION III - CONDITIONS OF PARTICIPATION

The results of diagnostic testing, including negative test results, billed by the podiatrist shall be indicated in the medical record of the patient. The date of the test shall be the same date for which the Kentucky Medicaid Program is billed.

These records shall be maintained in the recipient's case record for a period of not less than five (5) years from the date of service. Providers shall furnish to the Department or its authorized representative, as requested, information regarding any claims for services provided under the Medicaid Podiatry Program. Providers shall open medical files for review or copying by duly authorized representatives of the Cabinet for Health Services for the purpose of audits of claims for which Program payment has been made.

Notification in writing shall be made to the Medicaid Program regarding any change in Program participation status (e.g., change of ownership, address change).

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

A. COVERAGE

The Medicaid Program shall cover medical and surgical services provided to an eligible Medicaid recipient by a licensed, participating podiatrist if the services fall within the scope of the practice of podiatry except as specified in Section IV, B, (a) or (b). The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.

B. COVERAGE LIMITATIONS

1. Routine foot care.

Services characterized as routine foot care shall generally not be covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot.

a. Payment may be made for routine foot care such as cutting or removing corns, calluses or nails if the patient has a systemic disease of sufficient severity that unskilled performance of these procedures would be hazardous; the patient's condition must result from severe circulatory embarrassment or areas of desensitization in the legs or feet.

b. Services ordinarily considered routine shall also be covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections shall also be covered as they are considered outside the scope of "routine."

2. Limitations on Covered Laboratory Services

For Kentucky Medicaid to provide reimbursement for laboratory services a provider who performs any laboratory test shall apply for and be issued Clinical Laboratory Improvement Amendments (CLIA) certification, and possess a CLIA identification number.

Laboratory procedures performed in the podiatrist's office shall be limited to those procedures listed below. Reimbursement for the following services depend upon compliance with requirements listed in Section V, B.

Culture, screening	87081, 87082, 87083, 87084, 87085
definitive (bacteria and/or fungi)	87040, 87070, 87072, 87086, 87101
Smear, stained, bacteria or fungi	87205
Smear, wet mount, fungus	87208, 87210, 87211

A provider who performs any of the above laboratory tests may request information or apply for CLIA certification with the HEALTH CARE FINANCING ADMINISTRATION

Upon receipt of CLIA certification and issuance of a CLIA number, a podiatrist providing laboratory services shall provide a copy of the CLIA certification of approval and the CLIA number to Department for Medicaid Services; Individual Provider Services Branch; 275 East Main; Frankfort, Kentucky 40621. The podiatrist shall report his Kentucky Medicaid eight (8) digit provider number at the same time to facilitate cross-referencing.

C. PROVIDER-PATIENT CONTACTS

Pursuant to 907 KAR 3:005 Section 1, the Kentucky Medicaid Program shall provide reimbursement to a physician for a service provided for a recipient when

there is actual physician-patient contact. The provider shall bill Kentucky Medicaid for services actually performed. Charges shall not be submitted for a recipient who visits the office when the provider does not actually see and examine, treat or diagnose the recipient.

Additionally, charges shall not be submitted to Kentucky Medicaid when a service is performed or recipient contact is made exclusively by an assistant to the provider, employee, nurse, etc.

A telephone contact with the recipient shall not be recognized or payable as a visit. Therefore, the Program shall not be billed for a visit when telephone contact is the only service provided. Similarly, a contact between a provider or provider employee and the recipient for the sole purpose of obtaining a prescription or prescription refill shall not be considered a visit and the Program shall not be billed.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

A. REIMBURSEMENT

Reimbursement for a podiatrist shall be in accordance with 907 KAR 1:280, Section 2.

B. LABORATORY SERVICES

A provider who bills for a clinical laboratory code must comply with the requirements set forth in 42 CFR 493. A copy of the CLIA certification shall be sent to the Department for Medicaid Services, so that the CLIA number may be placed in the provider's file. Reimbursement for a clinical laboratory service shall be based on the lesser of the provider's usual and customary billed charge, or Medicare allowable payment rate. For a laboratory code which has no Medicare allowable fee on file, reimbursement shall be based on sixty-five (65) percent of the usual and customary actual billed charge.

C. REIMBURSEMENT IN RELATION TO MEDICARE

42 USC 1396 d(p) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible, and co-insurance amounts). Individuals entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMB's).

Some individuals will have dual eligibility for QMB benefits and regular Medicaid benefits.

The reimbursable services for these dual eligible, QMB only individuals, as well as the Medicare-Medicaid (non-QMB) eligible individuals, include co-insurance and deductible amounts for all Medicaid (Parts A and B) covered services or items regardless of whether the services or items are covered by Kentucky Medicaid.

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to Medicare when the provider has knowledge that Medicare is liable for payment of the services.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

D. FEE PAYMENT BY RECIPIENT

A participant in the program shall report a payment or deposit made toward a recipient's account, regardless of the source of payment. If the provider receives payment from an eligible Medicaid Program recipient for a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to a payment made by a recipient for spenddown or a non-covered service.

A recipient approved for Medicaid benefits on a spenddown basis shall be obligated to pay fees to a health care provider as assigned by their local Department for Social Insurance where eligibility is established. These fees shall be paid to the provider by the recipient and shall satisfy the excess income for the period of eligibility. These fee payments by the recipient shall be reported by the providers on the claim form as payments from other sources.

Any item or service provided for a Medicaid recipient not covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. A provider shall not collect fees from a recipient for a covered item or service for which Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

If a recipient has retroactive eligibility in which the individual receives a backdated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for a service during the retroactive eligible period will require a 100 percent refund to the recipient before the program may be billed.

PODIATRY MANUAL

APPENDICES

ICD-9 CM DIAGNOSIS CODES FOR COMMON PROCEDURES

*Diabetes mellitus				250.0
to specify	AODM	Juvenile Type	250.01	
Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)			440.9	440.2
Buerger's disease (thromboangitis obliterans)				443.1
Chronic thrombophlebitis			451.9	451.2
Peripheral neuropathies involving the feet:				355.9
*Associated with malnutrition and vitamin deficiency				269.2
malnutrition (general, pellagra)			263.9	265.2
alcoholism				357.5
Malabsorption (celiac disease, tropical sprue)				579.9
pernicious anemia				281.0
*Associated with carcinoma				199.1
*Associated with diabetes mellitus				250.6
*Associated with drugs and toxins				357.6
*Associated with multiple sclerosis			440.9	440.2
*Associated with uremia (chronic renal disease)				585
Associated with traumatic injury				356.9
Associated with leprosy or neurosyphilis				356.9
Associated with hereditary disorders				356.0
hereditary sensory radicular				356.2
neuropathy, angiokeratoma corposis			355.8	355.9
diffusm (Fabry's), amyloid neuropathy				277.3

APPENDIX II

Map - 122 (Rev. 10/96)

Kentucky Medical Assistance Pro
Drug Prior Authorization/Authorizatio

Requester: **Please** complete **Bold fields.**
Pharmacist **Please** complete all other fields

P. 0. Box 2036
Frankfort. KY 40602

MAID: _____ **Recipient Name:** _____

Pharmacy Provider Number. _____ **Prescribing Physician License Number.** _____

Pharmacy Name _____ **Physician Name:** _____

Address: _____ Address: _____

City: _____ **St:** ___ **zip:** _____ **City:** _____ **St:** ___ **Zip:** _____

Telephone Number: ( ) _____ **Telephone Number:** ( ) _____

PA Number: _____ **Drug** Name: _____ NDC: _____

Strength: _____ **Quantity:** _____ **Begin Date:** _____ End Date: _____

Diagnosis: _____

Prognosis: _____

Other Orugs Tried including OTC: _____

Prescription Directions: _____

Expected Length of Treatment: _____

Notes: _____

PA Number: _____ **Drug Name:** _____ **NDC:** _____

Strength: _____ **Quantity:** _____ Begin Date: _____ End Date: _____

Diagnosis: _____

Prognosis: _____

Other Orugs Tried including OTC: _____

Prescription Directions: _____

Expected Length of Treatment: _____

Notes: _____

CAUTION: **THE ABOVE RECIPIENT MUST BE ELIGIBLE ON THE DATE OF SERVICE. VERIFY BY CHECKING ME RECIPIENT'S MEDICAID CARD.**

DISAPPROVED

_ **Drug** is of **type already covered** on **DMS Formulary**

_ Drug **is rated** 'possibly or less than effective" by the FDA

___ Drug is to be used in accordance with FDA **stantards** and indications

___ Other

Mailroom use

Prior Authorization Unit
Prior **Authorization Requests** 1-800-756-7558
Billing Questions 1-800-756-7557